Request for Order and Consent - Paramedical Services **ADOPT**

PATIENT'S NAME
IHSS CASE NUMBER

DRAFT
Month Day, 20XX

Dear Licensed Health Care Professional (LHCP):

This patient has applied for In-Home Supportive Services (IHSS) and stated that he/she needs certain paramedical services for him/her to remain safely at home. Please indicate on this form what specific paramedical services are needed by completing sections 1-5 of this form.

For the purposes of IHSS, paramedical services are services that require judgment based on training provided by a LHCP, that are necessary to maintain the patient's health and that he/she would normally perform for himself/herself if not for his/her functional limitation(s); such as: the administration of medications, puncturing the skin or inserting a medical device into a body orifice, and activities requiring sterile procedures, among other things. These services will be provided by IHSS providers who are not licensed to practice health care and are not medically trained. If you order paramedical services, you are responsible for ensuring that the IHSS provider is trained to administer the paramedical services.

The time indicated to perform a specific paramedical service shall not be based on the ability of the IHSS provider, but rather on the time it would take an average person to perform the task for this patient. The Statewide Paramedical Services Time Guidelines are attached for you to use as a guide, and provides a range of time to perform each task, which allows for variation based on the individual needs of the patient. If the time necessary to perform the task for this patient falls outside of the timeframes listed in the attached Statewide Paramedical Services Time Authorization Guidelines (Time Guidelines), you must provide justification for the time ordered. <u>If you do not provide the required justification for indicating an amount of time that is outside the range specified in the Time Guidelines, the county will authorize time based on the in-home assessment and the Time Guidelines.</u>

Your examination of this patient is reimbursable through Medi-Cal as an office visit provided that all other applicable Medi-Cal provider requirements are met through the Department of Health Care Services (DHCS). You should submit billing to DHCS for payment for this office visit as you would with all other reimbursable Medi-Cal services.

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Your patient is requesting the following Paramedical Services:

_____

_____

_____

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_____

PARAMEDICAL SERVICES (EXAMPLES)	NON-PARAMEDICAL SERVICES (EXAMPLES)
-Ostomy irrigation/base change, enema or suppository insertion -Urine catheter, Foley replacement/irrigation -Injections -Glucose testing -G/J Tube: feeding, hydration, medication administration -Peritoneal/Central line home-dialysis -Wound cleaning	-Domestic and related services: i.e. meal preparation and cleanup, laundry, grocery shopping, routine maintenance of Respiratory Equipment, etc. -Personal care: i.e. Bathing, bed baths, grooming, oral hygiene, bowel, bladder, and menstrual care, assistance with Prostheses and Medications, -Stand-alone blood pressure and vital sign checks

If you have any questions about completion of this form, please contact the county Social Worker or Public Health Nurse at the following:

SOCIAL WORKER NAME or PUBLIC HEALTH NURSE NAME	SIGNATURE ▸
TELEPHONE NUMBER	EMAIL

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SECTIONS 1 THROUGH 5 TO BE COMPLETED BY THE LHCP
PLEASE PRINT CLEARLY:

1.

NAME OF LHCP	
OFFICE TELEPHONE NUMBER	MEDICAL LICENSE NO./MEDI-CAL PROVIDER NO.
OFFICE ADDRESS	
TYPE OF PRACTICE/MEDICAL SPECIALTY	
MEDICAL TITLE ☐PHYSICIAN/SURGEON/D.O. ☐PODIATRIST ☐PHYSICIAN ASSISTANT (PA) ☐NURSE PRACTITIONER (NP) ☐DENTIST	

2. DOES THE PATIENT HAVE A MENTAL OR PHYSICAL FUNCTIONAL LIMITATION WHICH RESULTS IN A NEED FOR ASSISTANCE BY AN IHSS PROVIDER FOR PARAMEDICAL SERVICES? ☐YES ☐NO

If YES, list the functional limitation(s) below:

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3. LIST THE PARAMEDICAL SERVICES WHICH ARE NEEDED AND SHOULD BE PROVIDED BY AN IHSS PROVIDER

*If the time required to perform the paramedical service for this patient falls outside of the attached Statewide Paramedical Services Time Guidelines due to the patient's specific circumstances, you must provide justification for the time ordered in the following section (section 4). You may attach separate pages if needed.

Example: Listing Paramedical Services

Type of Service	Time required to perform the service	Frequency		How long should this service be provided
Injection (insulin or other)	5 minutes	3 times	Daily	Continued

TYPE OF PARAMEDICAL SERVICE	*TIME (IN MINUTES) REQUIRED TO PERFORM THE PARAMEDICAL SERVICE	FREQUENCY AND NUMBER OF TIMES PERFORMED (DAILY, WEEKLY, ETC.)	HOW LONG DOES THIS SERVICE NEED TO BE PROVIDED? (Specify ongoing or provide an end date)

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4. ADDITIONAL COMMENTS TO EXPLAIN TIME OUTSIDE OF THE STATEWIDE PARAMEDICAL SERVICES TIME GUIDELINES (IF APPLICIBLE)

☐ Please check here if separate pages are attached.

5. PLEASE LIST IHSS PROVIDER(S) TRAINED TO PERFORM THIS/THESE PROCEDURE(S).

☐ Please check here if the IHSS provider is not at this appointment. He/she must complete the SOC 321A when he/she has received training directed by a LHCP to certify that he/she is able to perform the Paramedical Services.

IHSS PROVIDER(S) NAME	TRAINING PROVIDED BY	TYPE OF PARAMEDICAL SERVICE TRAINED ON	DATE OF TRAINING

LHCP CERTIFICATION	
I certify that I am licensed to practice in the State of California as specified above and that this order falls within the scope of my practice. In my judgment the paramedical services which I have ordered are necessary to maintain the patient's health and would normally be performed by the recipient for himself/herself if not for his/her functional limitation(s). I shall provide such direction as needed, in my judgment, in the provision of the ordered paramedical services. I have informed the patient of the risks associated with the provision of the ordered paramedical services.	
LHCP SIGNATURE ▸	DATE

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IHSS RECIPIENT'S INFORMED CONSENT

***Social Worker may have recipient complete informed consent prior to the LHCP completing SOC 321.**

BE SURE YOU HAVE READ EVERY ITEM AND ANSWERED ALL THE QUESTIONS THAT APPLY TO YOU. READ THE FOLLOWING CAREFULLY BEFORE SIGNING:

I the undersigned have been advised of risks associated with the provision of the paramedical services listed above and consent to the provision of these services by my IHSS provider(s).

I accept the responsibility for allowing this person named on the SOC 321 and/or 321A form to perform these paramedical services and I understand the County and the State of California are immune from any related liability.

I agree to inform the County Department of Social Services if there are any changes in my condition that changes my need for paramedical services.

I agree to have a new SOC 321 completed if I have a need for new paramedical service(s).

I agree to notify the county if my provider(s) of these paramedical services changes. This includes when a new provider will be performing my paramedical services or my existing provider quits or is fired.

I agree to inform my IHSS provider(s) of my existing paramedical service needs and inform him/her that he/she must get the necessary training in order to properly perform these services for me and get paid for performing these services.

I THE UNDERSIGNED DECLARE UNDER PENALTY OF PERJURY THAT THE FORGOING STATEMENTS ARE TRUE AND CORRECT.

IHSS RECIPIENT'S SIGNATURE ▸	DATE
AUTHORIZED REPRESENTATIVE (IF RECIPIENT CANNOT SIGN ON THEIR OWN BEHALF)	
RELATIONSHIP TO RECIPIENT	TELEPHONE NUMBER
SIGNATURE	DATE

Return to: (County Social Services/IHSS Department)
